STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235375	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Applewood Nursing Center Inc	18500 Van Horn Rd Woodhaven, MI 48183

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to maintain catheter bag privacy for one (R411) of three residents reviewed for catheter care. Findings include: On 9/18/24 at 10:00 AM and at 11:25 AM, R411's room door was open, and their catheter bag was observed hanging on the side of the bed facing the doorway clearly visible from the hallway and passersby. The catheter bag was clear and was not in a privacy bag. Yellow-colored urine was visible in the bag. On 9/18/24 at 12:05 PM, R411's catheter bag remained clearly visible from the hallway, uncovered and containing urine. R411's roommates family member entered the room to visit. R411 stated It bothers me that the foley bag isn't covered up. I'm not old enough for a foley and everyone (R411 pointed to her roommate's family member) can see it. I have an issue with it. Review of the Electronic Health Record (EHR) for R411 revealed an admitted [DATE] with diagnoses that included obstructive and reflux uropathy and obesity. The Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. On 9/18/24 at 12:25 PM, Certified Nursing Assistant (CNA) E was interviewed and agreed R411's foley collection bag did not have a privacy bag on the bed and could be seen from the hallway and visitors in the room. CNA E said catheter bags should be placed in a privacy bag to maintain resident's dignity. On 9/20/24 at 10:02 AM, the facility Director of Nursing (DON) said the expectation is that a catheter bag should be covered by a privacy bag. Review of the facility policy Indwelling Catheter Care and Maintenance reviewed 10/2021 revealed in part . Provide resident dignity by placing the drainage bag in a dignity bag.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on interview and record review the facility failed to develop, implement, and revise care plans for one resident (R404) of four residents reviewed with a tube feeding, resulting in multiple hospital admissions for peg tube reinsertion. Findings include: On 9/18/24 at 9:00 A.M., review of the Admission Record for R404 indicated the resident was admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following a cerebral infraction (stroke) affecting the left non dominant side, vascular dementia, dysphagia with J/G tube (Tube placed in the jejunum/stomach for feeding liquid nutrition), end stage renal disease requiring dialysis and Hypotension. Review of the Minimum Data Set (MDS), dated [DATE], R404 had a BIMs (Brief Interview for Mental Status of 14 (cognitively intact), required two person assist with ADL's (Activities of Daily Living) was NPO (nothing by mouth) and received a tube feeding for nutritional needs. On 9/18/24 at 9:15 A.M., complainant H reported to the State Agency R404 had been transferred to the hospital seven times for the replacement of a peg tube (a tube inserted into the stomach to provide liquid nutrition). The complainant indicated R404 had an ongoing problem with the peg tube malfunctioning and dislodgement. The complainant reported, R404 had aspirated toward the end of 2023 but thought seven transfers to the hospital for the same issue was excessive. On 9/18/24 at 12:30 P.M. and on 1/19/24 at 2:00 P.M., review of the care plan section of R404's electronic Medical Record revealed there were no care plans addressing R404 behavior for manipulating the peg tube or tubing, no identification of the fluid restriction for the enteral feeding and or water flushes. In addition, the care plans did not address any interventions to reduce the frequency of transferring to the hospital for care of the peg tube. The care plan dated 6/4/24, documented, (R404) requires tube feeding related to dysphagia swallowing problem focused on R404 being at risk for aspiration. Noncompliance of head of bed positioning. This care plan had not been updated or revised since the resident's problem was identified. On 9/19/24 at 1:05 P.M. the Director of Nursing indicated the care plans should have been revised after R404 returned for each hospital transfer. The DON acknowledged R404 had multiple transfers but provided no explanation why it wasn't identified as a concern . On 9/19/24 at 3:30 P.M. review of the facility's Care Plan policy dated 5/21, stated in part under #4. Any member of the IDT (Interdisciplinary Team) may request a special care conference if there is an issue that needs to be address.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 This citation pertains to MI00144652, MI00145045, and MI00145057 Based on interview and record review the facility failed to implement interventions to prevent the dislodgement and manipulation of a percutaneous enteral gastrostomy tube in a timely manner (PEG) for one (R404) of four residents reviewed for quality of care, resulting in ten (10) hospital transfers/admissions for treatment and care of a peg tube/J-tube. Findings include: On 9/18/24 at 9:00 A.M., review of the Admission Record for R404 indicated the resident was admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following a cerebral infraction (stroke) affecting the left non dominant side, vascular dementia, dysphasia with J/G tube (Tube placed in the jejunum/stomach for feeding liquid nutrition), end stage renal disease requiring dialysis and Hypotension. Review of the Minimum Data Set (MDS), dated [DATE], R404 had a BIMS (Brief Interview for Mental Status of 14 (cognitively intact), required two person assist with ADL's (Activities of Daily Living), was NPO (nothing by mouth), and received a tube feeding for nutritional needs. On 9/18/24 at 9:15 A.M., complainant H reported to the State Agency R404 had been transferred to the hospital seven times for the replacement of a peg tube (a tube inserted into the stomach to provide liquid nutrition). The complainant indicated R404 had an ongoing problem with the peg tube malfunctioning and dislodgement. The complainant stated,(R404) had aspirated toward the end of 2023 but thought seven transfers to the hospital for the same issue was excessive. On 9/18/24 at 3:42 P.M. review of the Census List (Form used by the facility to document and track billing/ transfers to the hospital) revealed R404 was transferred to the hospital for dislodgement/blockage of the peg tube on the following listed dates: 9/13/23, 10/24/23, 11/25/23, 12/21/23, 1/3/2024, 2/12/24, 3/25/24, 4/16/24, 5/22/24 and 6/1/2024. There was a total of 11 transfers with eight being repeated issues concerning the PEG tube. On 9/18/24 at 4:00 P.M. review of the Dietitian's Monthly Review dated 1/29/24 and 2/14/24 revealed R404 was NPO, and recommended the facility send for J-tube placement if resident cannot tolerate PEG. Nutrition (NTR) and weight will continue to decline due to tube feeding not meeting needs. Per Dietitian's Monthly Review dated 3/17/24, R404 was finally given J tube. However, R404 continued to manipulate/dislodge the J-tube. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 4:10 P.M. the Director of Nursing (DON) was interviewed concerning R404 being transferred to the hospital seven or more times for the same concern of peg tube blockage and or malfunctioning. The DON was asked what interventions were implemented to prevent R404 from being sent to the hospital for the same issue (blockage/dislodgement of the PEG/J-tube) repeatedly? The DON was not sure how many times R404 had been sent to the hospital for the G-tube to be changed to a J tube but, stated, The staff had talked about changing the type of tube feeding pump. When asked, the DON was unable to provide an answer regarding interventions put in place to prevent R404 from manipulating/dislodging feeding which led to the resident being admitted to the hospital multiple times. The DON was not aware and unsure of any other interventions. The DON indicated she would review the EMR (Electronic Medical Record). The DON added that the interventions were part of an investigation that had been completed by the facility after the family made an allegation of neglect. On 9/19/24 at 10:30 A.M., record review of the facility's undated investigation, signed by the DON 6/17/24, pertaining to the seven hospital transfers for the Peg tube malfunction/blockage documented the following as a plan of action upon the resident returning to the facility on [DATE]. At this time R404 had been transferred to the hospital six times. Resident currently not in facility Continue with kangaroo tube feeding pump . Will attempt a larger abdominal binder upon return with evaluation of tubing to ensure tubing isn't occluded and possibly use during transfer only to secure tube. No explanation was provided why it took seven or more transfers to the hospital before an abdominal binder was identified as an intervention. Further interview with the DON concerning witness statements from the investigation revealed three nurse assistants verified R404 had use of his right hand and potentially was manipulating his bed remote and moving the head of the bed and dislodging/manipulating the tube feeding himself. The use of an abdominal binder was discussed in the past but disregarded due to the risk of occluding the resident's continuous tube feeding. The DON was asked to explain the length of time it took to address R404's PEG tube concerns without the implementation of interventions when the Nurse Aides reported their observations. No explanation was provided. When asked if R404 was referred to psych services, the DON stated the facility did not receive consent for an antidepressant. There was no evidence or documentation of whether R404 was offered or referred for consultation with a psychiatrist. On 9/19/24 at 2:30 P.M. Physician F was interviewed concerning the seven or more transfers to the hospital. The physician indicated staff thought the resident was trying to harm himself. Physician F did not provide any reasons or explanation of why R404 continued to be transferred to the hospital for the same concern. On 9/19/24 at approximately 3:10 p.m., during the exit interview, the Administrator and DON provided no additional information or evidence related to R404.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to implement interventions to address a chronic leaking indwelling urinary catheter (foley) for one resident (R412) of three residents reviewed for catheter care resulting in the worsening and infection of a sacral Stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur). Findings include: On [DATE] at 11:20 AM R412 was observed in a perimeter air mattress bed with a foley catheter and stated, I have been having problems with my catheter leaking. I have been waiting for my insurance to go through so that I can see the urologist. My catheter keeps leaking and has reopened the wound on my bottom. According to R412's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis (MS), Neuromuscular dysfunction of bladder and Pressure Ulcer of Sacral Region. According to the Minimum Data Set (MDS) assessment dated [DATE], (R412) had intact cognition and required extensive assist of 2 persons for bed mobility. On [DATE] a skin/wound note documented, (R412) sacrum has changed shape and is slightly deeper. Wound has a pink base with a skin bridge. (R412) continues to have a problem with the foley catheter. (R412) has an appt tomorrow with urology. Right ischium wound continues to be closed. On [DATE] a health status note documented, Guest (R412) returned from scheduled urology appointment not seen due to guest not having current insurance. On [DATE] a health status note documented Cancel appointment due to insurance pending. Will reschedule when guest has insurance. Office put in guest chart why appointment was cancelled. On [DATE] the Wound Care Practitioner's note indicated The patient is seen for multiple wounds located on buttocks, hips, sacrum, pain is intermittent, there are no signs and symptoms of infection. (R412) had a Stage 4 pressure ulcer on the right sacral area that measured: 3.0cm (centimeter) x 0.6 cm x 0.3 cm depth with an area of 1.8 sq cm and a volume of .54 cubic cm. Wound bed has ,d+[DATE]% granulation. The wound is improving. Right ischial recurrent is a chronic stage 3 pressure injury that measured 1.2cm length x 2cm width x 0.1 cm depth, with an area of 2.4 sq cm and a volume of 0.24 cubic cm. Wound bed has , d+[DATE]% slough, ,d+[DATE]% epithelization. The wound is improving. Left sacral is a stage 4 pressure injury pressure ulcer and has received and outcome of resolved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] the Wound Care Practitioners note indicated The patient was seen for a follow up wound care visit for the left sacral (reopened) right sacral, right ischial. The sacral wound has yellow slough at the wound bed. The right sacral has deceased in size, however increased in depth. The right ischial has reopened. The patients foley catheter is leaking again which is a contributing factor to wounds stalling. The left sacral recurrent is a stage 4 pressure injury and has received a status of not healed. Measurements are 2.5cm length x 1.7 cm width with no measurable depth with an area of 4.25 sq cm. The wound margin is attached to wound base wound bed has ,d+[DATE] slough. The wound is stalled. On [DATE] the Wound Care Practitioners note indicated The patient was seen for a follow up wound care visit for the bilateral sacral wound, right ischial wound. The sacral wounds have conjoined and now one wound. New rigid bone exposure found in sacral wound. Antibiotic therapy initiated; X-ray ordered to rule out osteomyelitis. Bilateral sacral deep tissue injury is a stage 4 injury pressure ulcer with measurements 9cm length x 4.2 cm width x 0.6 cm depth with an area of 37.8 sq cm and a volume of 22.68 cubic cm. Wound bed has ,d+[DATE]% granulation ,d+[DATE]% slough. The wound is stalled. Record review of physician's orders for R412 dated [DATE] revealed Bactrim DS Oral Tablet ,d+[DATE] MG (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth two times a day for wound infection, possible osteomyelitis for 7 Days [DATE] to [DATE]. Review of the care plan revealed, Focus: Potential/at risk for alteration in skin integrity due to risk factors associated with contractures of legs, immobility, incontinence (bowel and bladder), pain MS date initiated [DATE]. Goal: Resident will have no complications thru next review date. Initiated [DATE] revised on [DATE] Interventions included, .Provide peri care after each incontinent episode and apply barrier cream initiated [DATE] and .Keep linens dry and wrinkle free initiated [DATE]. Review of the care plans revealed, Alteration in skin integrity-Resident has pressure injury. Site hx of sacrum, coccyx, bilateral ischial tuberosity left I, healed left lateral foot, healed right ischial open, hx right lateral foot all pressure areas on admission. Factors that may inhibit wound healing immobility, incontinence, MS, contracted initiated [DATE] revised [DATE]. Goal: resident will be free from complications thru next review date initiated [DATE] revision on [DATE]. One of the interventions included, Peri care after each incontinent episode and apply barrier cream [DATE]. The Alteration in skin integrity care plan though initiated prior to R412's wound reopening, did not address the leaking foley catheter. Review of R412's care plan revealed Focus: I am on antibiotic related to sacral wound infection; date initiated [DATE]. Focus: I have an indwelling catheter related to stage 4 pressure ulcer to sacrum and multiple sclerosis, neurogenic bladder. Date initiated [DATE]. On [DATE] at 2:10 PM Registered Nurse (RN) A was interviewed and said (R412) has been on the same size Foley catheter for months and it has been leaking since May/[DATE]. We sent R412 to a urologist to be evaluated in June but the urologist would not see them due to lack of insurance. We are waiting for (R412's) insurance to get approved to send them back to the urologist. RN A stated I notified the Nursing Home Administrator (NHA) and Director of Nursing (DON) and Business Office Manager (BOM) in [DATE] that R412 was refused a urology visit due to lack of insurance and notified the NHA and DON that the foley catheter was leaking. RN A agreed R412's chronic leaking catheter contributed to the wounds not healing and getting infected. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:10 PM Business Office Manager (BOM) B was interviewed and said she made the NHA aware of R412's lapsed insurance in [DATE] and was working with R412 to reapply. On [DATE] at 9:45 AM Licensed Practical Nurse (LPN) C was interviewed and said R412 has had a leaking catheter all summer and agreed urine could be affecting the wounds' ability to heal and contributed to an infection. LPN C also said she is in frequent contact with RN A regarding R412's care and was aware of R412 not being seen by urology due to a lack of insurance and said that R412's leaking catheter concern was brought up to the interdisciplinary meeting in [DATE]. On [DATE] at 12:45 PM LPN D was interviewed and said she became aware of the antibiotic ordered for R412 on [DATE] in morning meeting due to R412's sacral wound getting worse and infected. LPN D also said that there was no wound culture performed and did not offer an explanation. A urology appointment was not scheduled for R412 until [DATE]. Record review of a health status note dated [DATE] documented (R412) has been scheduled for urology appointment on [DATE] urology office to be bill facility for visit. On [DATE] at 2:30 PM the DON was interviewed and declined to answer if the facility should have paid for and rescheduled R412's urology appointment. On [DATE] at 3:10 PM the NHA was interviewed and agreed it was the facilities' responsibility to schedule and pay for R412's urology appointment. Review of the facility policy titled Indwelling Catheter care and maintenance reviewed ,d+[DATE] revealed in part .A current diagnosis and physician's order will be required to retain the indwelling catheter. Possible diagnosis to retain an indwelling catheter may include the following: To assist with healing of Stage 3 or 4 sacral injuries. Indwelling catheters, drainage bags and tubing will be changed upon clinical indication of infection, obstruction or when the closed system is compromised.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to provide comprehensive foley catheter care for one resident (R412) of three residents reviewed for catheter care resulting in a chronic leaking foley catheter and resident concerns with reopening a sacral wound. Findings include: On 9/18/2024 at 11:20 AM R412 was observed in a perimeter air mattress bed with a foley catheter and stated, I have been having problems with my catheter leaking. I have been waiting for my insurance to go through so that I can see the urologist. My catheter keeps leaking and has reopened the wound on my bottom. According to R412's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis, Neuromuscular dysfunction of bladder and Pressure Ulcer of Sacral Region. According to the Minimum Data Set (MDS) assessment dated [DATE], R412 had intact cognition and required extensive assist of 2 persons for bed mobility. On 6/10/24 a skin/wound note documented (R412) sacrum has changed shape and is slightly deeper. Wound has a pink base with a skin bridge. R412 continues to have a problem with the foley catheter. R412 has an appt tomorrow with urology. Right ischium wound continues to be closed. On 6/11/24 a health status note documented Guest (R412) returned from scheduled urology appointment not seen due to guest not having current insurance. On 6/14/24 a health status note documented Cancel appointment due to insurance pending. Will reschedule when guest has insurance. Office put in guest chart why appointment was cancelled. On 9/2/24 the Wound Care Practitioners note indicated The patient was seen for a follow up wound care visit for the left sacral (reopened) right sacral, right ischial . The patients foley catheter is leaking again which is a contributing factor to wounds stalling. The left sacral recurrent is a stage 4 pressure injury and has received a status of not healed . The wound is stalled. On 9/9/24 the Wound Care Practitioners note indicated, The wound is stalled. Review of R412's care plan revealed Focus: I am on antibiotic related to sacral wound infection; date initiated 9/10/24. Focus: I have an indwelling catheter related to stage 4 pressure ulcer to sacrum and multiple sclerosis, neurogenic bladder. Date initiated 6/20/23. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 9/18/24 at 2:10 PM Registered Nurse (RN) A was interviewed and said R412 has been on the same size Foley catheter for months and it has been leaking since May/June 2024. We sent R412 to a urologist to be evaluated in June but the urologist would not see them due to lack of insurance. We are waiting for R412's insurance to get approved to send them back to the urologist. RN A stated I notified the Nursing Home Administrator (NHA) and Director of Nursing (DON) and Business Office Manager (BOM) in June 2024 that R412 was refused a urology visit due to lack of insurance and notified the NHA and DON that the foley catheter was leaking. RN A agreed R412's chronic leaking catheter contributed to the wounds not healing and getting infected. On 9/18/24 at 3:10 PM BOM B was interviewed and said she made the NHA aware of R412's lapsed insurance in June 2024 and was working with R412 to reapply. On 9/19/24 at 9:45 AM Licensed Practical Nurse (LPN) C was interviewed and said R412 has had a leaking catheter all summer and agreed urine could be affecting the wounds' ability to heal and contributed to an infection. LPN C also said she is in frequent contact with RN A regarding R412's care and was aware of R412 not being seen by urology due to a lack of insurance and said that R412's leaking catheter concern was brought up to the interdisciplinary meeting in June 2024. On 9/12/24 at 12:45 PM LPN D was interviewed and said she became aware of the antibiotic ordered for R412 on 9/11/24 in morning meeting due to R412's sacral wound getting worse and infected. A urology appointment was not scheduled for R412 until 9/19/24. Record review of a health status note dated 9/19/24 documented (R412) has been scheduled for urology appointment on 9/20/24 urology office to be bill facility for visit. On 9/18/24 at 2:30 PM the DON was interviewed and declined to answer if the facility should have paid for and rescheduled R412's urology appointment. On 9/18/24 at 3:10 PM the NHA was interviewed and agreed it was the facilities' responsibility to schedule and pay for R412's urology appointment. Review of the facility policy titled Indwelling Catheter care and maintenance reviewed 10/2021 revealed in part: . Possible diagnosis to retain an indwelling catheter may include the following: To assist with healing of Stage 3 or 4 sacral injuries. Indwelling catheters, drainage bags and tubing will be changed upon clinical indication of infection, obstruction or when the closed system is compromised.